STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the investigation of complaint number IN00113312. Complaint number IN00113312, unsubstantiated, due to lack of evidence. Unrelated deficiency cited Survey dates: August 6 and 7, 2012 Facility number: 000305 Provider number: 155625 Aim: 100287200 Survey team: Sharon Lasher RN Census bed type: SNF/NF: 74 Total: 74 Census payor type: Medicare: 8 Medicaid: 60 Other: 6 Total: 74 Sample: 9 These deficiencies reflects state findings cited in accordance with 410 IAC 16.2.	F0000	The creation and submission of this plan of correction does not consitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after August 25, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed 8/10/12 Cathy Emswiller RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on record review and interview the facility failed to protect 1 resident's privacy and confidentiality, in that a picture of one resident's leg was taken by one CNA and the picture was sent to another CNAs cell phone. This deficient practice affected 1 resident of 9 residents reviewed for personal privacy and	F0164	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The two CNA's involved were terminated from the facility. The family and physician of the affected resident were notified. The affected was unaware the	08/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	confidentiality in a sample of 9. (Resident #D) Findings include: During an interview on 8/7/12 at 10:00 a.m., the Administrator indicated she had terminated CNA #2 and CNA #3 yesterday. She indicated CNA #1 informed her of a picture that was taken of Resident #D's left upper thigh. After investigating it was found CNA #2 showed CNA #1 a picture on her cell phone of a bruise on Resident #D's upper thigh. CNA #3 indicated she held resident #D's leg while CNA #2 took a picture and text it to CNA #3's cell phone. Review of information, sent to ISDH on 8/6/12 indicated "CNA, #1, reported to the Administrator on 8/6 at 2:00 p.m., CNA #2 had showed her, CNA #1, a picture on CNA #2's phone of a bruise on Resident #D's posterior left upper thigh. After investigation, it was verified by another staff member that CNA #2, showed a picture of this bruise, to two CNA's. CNA #3, stated that 'I held up the resident's legs while CNA #2 took the picture then CNA #2 text the picture to my cell phone.' A undated. policy provided by the Administrator on 8/7/12 at 3:10 p.m.,		incident occurred and the incident has had no negative effects on the affected residents psychosocial well-being. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents are at risk of being affected by the alleged deficient practice. Staff was in-serviced regarding cell phone, resident rights, and photograph policies on 8/15/2012 by Director of Nursing and the Assistant Director of Nursing. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Both CNA's involved in the incident were terminated. Staff was in-serviced regarding cell phone, resident rights, and photograph policies on 8/15/2012. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Continuous Quality Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated "Telephones/Pagers/Cell Phones", "The use of personal pagers or cell phones is not permitted during working hours unless your job requires the use of such a device. Caught using these devices could be grounds for disciplinary action." "Camera Phones", "The Company prohibits employee possession or use of cameras in the workplace, including camera phones, as a preventative step believed necessary to secure employee privacy, trade secrets and other business information. The use of the camera phone feature of any cell phone is strictly prohibited at all times and is never to be used on company property. Caught using these devices will result in disciplinary action; up to and including termination." "Photographs", "Residents must not be photographed unless they have signed a permission form and are cognizant to know what they are approving. To protect the resident's rights, refer outside persons, media, or others who want to take photographs to the Executive Director/Director of Nursing/General manager/Clinical Director." During an interview on 8/7/12 at 3:20 p.m., DON (Director of Nursing) indicated staff are not permitted to have cell phone while they are working. Staff are supposed to put their cell phone in		monitoring tool will be used to monitor staff adherence to cell phone policies monthly for 3 months and then quarterly for 3 quarters by Executive Director or designee. This will be reviewed by the Quality Assurance Team. Cell phone usage will be monitored by Nurses and Supervisors during regular facility walk through and observation on all 3 shifts. - by what date the systemic changes will be completed. Completion date will be 08/25/2012.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	their purse or in the CNA room in their locker. 3.1-3(o)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview the facility failed to ensure 1 resident did not experience mistreatment for 1 of 9 residents in a sample of 5 reviewed for mistreatment. (Resident #D) Findings include: Resident #D's record was reviewed on 8/7/12 at 12:30 p.m. Resident #D's MDS (Minimum Data Set), assessment, indicated Resident scored 0 on the Brief Interview for Mental Status with a score of 0-7 indicating severe impairment. The MDS also indicated Resident #D was totally dependent for transfers, unable to walk, and her functional status was totally dependent. During an interview on 8/7/12 at 10:00 a.m., the Administrator indicated CNA #3 had informed her of CNA #2 taking a picture of Resident #D's left upper thigh with her cell phone while CNA #3 held Resident #D's leg up to take a picture of a	F0224	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The two CNA's involved were terminated from the facility. The family and physician of the affected resident were notified. The affected was unaware the incident occurred and the incident has had no negative effects on the affected residents psychosocial well-being. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents are at risk of being affected by the alleged deficient practice. Staff was in-serviced regarding cell phone, resident rights, and photograph policies on 8/15/2012 by Director of Nursing and the Assistant Director of Nursing. - what measures will be put into place or what systemic	08/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bruise on her leg and after CNA #2 took the picture she text it to CNA #3. 3.1-28(a)		changes will be made to ensure that the deficient practice does not recur; Both CNA's involved in the incident were terminated. Staff was in-serviced regarding cell phone, resident rights, and photograph policies on 8/15/2012. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Continuous Quality Improvement monitoring tool will be used to monitor staff adherence to cell phone policies monthly for 3 months and then quarterly for 3 quarters by Executive Director or designee. This will be reviewed by the Quality Assurance Team. Cell phone usage will be monitored by Nurses and Supervisors during regular facility walk through and observation on all 3 shifts. - by what date the systemic changes will be completed. Completion date will be 08/25/2012.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview the facility failed to follow their policy and procedure to protect 1 resident's privacy and confidentiality in a sample of 9. (Resident #D) Findings include: Resident #D's record was reviewed on 8/7/12 at 12:30 p.m. Resident #D's MDS (Minimum Data Set), assessment, indicated Resident scored 0 on the Brief Interview for Mental Status with a score of 0-7 indicating severe impairment. The MDS also indicated Resident #D was totally dependent for transfers, unable to walk, and her functional status was totally dependent. During an interview on 8/7/12 at 10:00 a.m., the Administrator indicated CNA #3 had informed her of CNA #2 taking a picture of Resident #D's left upper thigh with her cell phone while CNA #3 held Resident #D's leg up to take a picture of a	F0226	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The two CNA's involved were terminated from the facility. The family and physician of the affected resident were notified. The affected was unaware the incident occurred and the incident has had no negative effects on the affected residents psychosocial well-being. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents are at risk of being affected by the alleged deficient practice. Staff was in-serviced regarding cell phone, resident rights, and photograph policies on 8/15/2012 by Director of Nursing and the Assistant Director of Nursing. - what measures will be put into place or what systemic changes will be made to ensure	08/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bruise on her leg and after CNA #2 took the picture she text it to CNA #3. A undated. policy provided by the Administrator on 8/7/12 at 3:10 p.m., indicated "Telephones/Pagers/Cell Phones", "The use of personal pagers or cell phones is not permitted during working hours unless your job requires the use of such a device. Caught using these devices could be grounds for disciplinary action." "Camera Phones", "The Company prohibits employee possession or use of cameras in the workplace, including camera phones, as a preventative step believed necessary to secure employee privacy, trade secrets and other business information. The use of the camera phone feature of any cell phone is strictly prohibited at all times and is never to be used on company property. Caught using these devices will result in disciplinary action; up to and including termination." "Photographs", "Residents must not be photographed unless they have signed a permission form and are cognizant to know what they are approving. To protect the resident's rights, refer outside persons, media, or others who want to take photographs to the Executive Director/Director of Nursing/General manager/Clinical Director."		that the deficient practice does not recur; Both CNA's involved in the incident were terminated. Staff was in-serviced regarding cell phone, resident rights, and photograph policies on 8/15/2012. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Continuous Quality Improvement monitoring tool will be used to monitor staff adherence to cell phone policies monthly for 3 months and then quarterly for 3 quarters by Executive Director or designee. This will be reviewed by the Quality Assurance Team. Cell phone usage will be monitored by Nurses and Supervisors during regular facility walk through and observation on all 3 shifts. - by what date the systemic changes will be completed. Completion date will be 08/25/2012.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 8/7/12 at 3:20 p.m., DON (Director of Nursing) indicated staff are not permitted to have cell phone while they are working. Staff are supposed to put their cell phone in their purse or in the CNA room in their locker. 3.1-28(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on record review and interview the facility failed to ensure the dignity for 1 of 9 residents reviewed for dignity in a sample of 9. (Resident #D) Findings include: Resident #D's record was reviewed on 8/7/12 at 12:30 p.m. Resident #D's MDS (Minimum Data Set), assessment, indicated Resident scored 0 on the Brief Interview for Mental Status with a score of 0-7 indicating severe impairment. The MDS also indicated Resident #D was totally dependent for transfers, unable to walk, and her functional status was totally dependent. During an interview on 8/7/12 at 10:00 a.m., the Administrator indicated CNA #3 had informed her of CNA #2 taking a picture of Resident #D's left upper thigh with her cell phone while CNA #3 held Resident #D's leg up to take a picture of a bruise on her leg and after CNA #2 took	F0241	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The two CNA's involved were terminated from the facility. The family and physician of the affected resident were notified. The affected was unaware the incident occurred and the incident has had no negative effects on the affected residents psychosocial well-being. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents are at risk of being affected by the alleged deficient practice. Staff was in-serviced regarding cell phone, resident rights, and photograph policies on 8/15/2012 by Director of Nursing and the Assistant Director of Nursing. - what measures will be put into place or what systemic changes will be made to ensure	08/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the picture she text it to CNA #3. 3.1-3(t)		that the deficient practice does not recur; Both CNA's involved in the incident were terminated. Staff was in-serviced regarding cell phone, resident rights, and photograph policies on 8/15/2012. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Continuous Quality Improvement monitoring tool will be used to monitor staff adherence to cell phone policies monthly for 3 months and then quarterly for 3 quarters by Executive Director or designee. This will be reviewed by the Quality Assurance Team. Cell phone usage will be monitored by Nurses and Supervisors during regular facility walk through and observation on all 3 shifts. - by what date the systemic changes will be completed. Completion date will be 08/25/2012.	